## What this form is used for

**Supporting Information:** in order for the University to provide you with support, adjustments and exam arrangements during your studies, we need a medical professional to provide information about your disability. This could be from your GP, Consultant, or other medical professional.

Don’t complete this form if you have a specific learning difficulty (e.g. dyslexia). Instead, you need to send us a diagnostic report from an Educational Psychologist or a Specialist Teacher with a current active Assessment Practicing Certificate (APC). If you have any questions about this contact us at disability@leeds.ac.uk.

## What you need to do

1. You need to complete your details in **Section 1** of this form.
2. You should then give this form to the **medical professional** so that they can complete the rest of the form and sign the declaration.
3. Either you or the medical professional must then **return this form to Disability Services** at the University of Leeds. You can do this in the following ways:
	* by email to disability@leeds.ac.uk (this is the preferred option)
	* by bringing the form to Disability Services reception in Chemistry West
	* by posting the form to us at Disability Services, University of Leeds, Leeds, LS2 9JT.

If you need further advice on completing this form, or about supporting information, please contact Disability Services by email at disability@leeds.ac.uk, by phone on 0113 343 3927, or in person.

# Section 1: Personal Details

|  |  |
| --- | --- |
| **Student ID Number** |  |
| **First Name(s)** |  |
| **Last Name** |  |
| **Date of Birth** |  |

**Now give this form to the medical professional**

# Section 2: Medical Professional Details

|  |  |
| --- | --- |
| **Full Name** |  |
| **Job title** |  |
| **Certificate or registration number** |  |
| **Are you medically qualified to diagnose the student’s disability or medical condition?**  | [ ]  Yes [ ]  No |

|  |  |
| --- | --- |
| **Type of practice or organisation** | [ ]  GP Practice[ ]  Primary Care Team[ ]  Secondary Care Team[ ]  Hospital[ ]  Other (give details below) |
| **Name of practice or organisation** |  |
| **Address** |  |
| **Contact Number** |  |
| **Practice or organisation stamp (required).** If not available, this form must be accompanied by a note on headed paper, signed and dated by the signatory of this form, or sent from a verifiable email address.  |  |

# Section 3: About the student’s disability or condition

**Using your professional judgement, please answer the following questions:**

|  |  |
| --- | --- |
| Does the student have a physical, sensory or mental health disability which has a substantial adverse effect on their ability to carry out **typical daily activities**, including activities relating to studying? If yes, please give details in “other information”.  | [ ]  Yes[ ]  No |
| Is this considered **‘long term’**, i.e. has lasted, or is likely to last for 12 months or more, or for the rest of the student’s life? | [ ]  Yes[ ]  No |
| Is this disability, or the symptoms of it, likely to **fluctuate** over time? If yes, please provide further details below in “other information”.  | [ ]  Yes[ ]  No |
| Will this disability affect **travel to** campus (e.g. walking or using public transport)? If yes, please provide further details below in “other information”. | [ ]  Yes[ ]  No |
| Will this disability affect **mobility around** campus (e.g. moving between teaching venues)? If yes, please provide further details below in “other information”. | [ ]  Yes[ ]  No |
| Will this **only** affect the student in **examinations**, and not in the rest of their studies or daily activities? (e.g. exam anxiety, difficulty with extensive handwriting). If yes, please provide further details below in “other information”.  | [ ]  Yes[ ]  No |

|  |  |
| --- | --- |
| **Please confirm the diagnosis OR working diagnosis**(If it’s not possible to give either, please explain why) |  |
| **Date of diagnosis or last assessment** |  |
| **Other information/impact** (continue in the box at the end of the form if required) |   |

# Section 4: Medical professional declaration

Please sign and date below to confirm that, to the best of your knowledge, the information you’ve provided is true and complete.

|  |  |
| --- | --- |
| **Medical professional signature** | **Date** |

** Please give this form back to the student or return to the University of Leeds at** **disability@leeds.ac.uk****.**

**Additional information (use if required)**